IDAHO DEPARTMENT OF
HEALTH & WELFARE

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RICHARD M. ARMSTRONG – Director

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February 3, 2010

Merinda Halladay, Administrator
Belmont Care Center
3625 Vaughn Street
Pocatello, Idaho 83204

RE: Belmont Care Center, Provider #13G046

Dear Ms. Halladay:

This is to advise you of the findings of the Medicaid/Licensure Fire Life Safety Survey, which was concluded at Belmont Care Center, on January 26, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. **It is important that your Plan of Correction address each deficiency in the following manner:**

1. What corrective action(s) will be accomplished for those individuals found to have been affected by the deficient practice;

2. How you will identify other individuals having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;

3. What measures will be put in place or what systemic change you will make to ensure that the deficient practice does not recur;

4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,

5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance

within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions which require construction, competitive bidding, or other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **February 16, 2010**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208) 334-6626.

Sincerely,

FOR

TAYLOR BARKLEY
Health Facility Surveyor
Fire Life Safety & Construction Program

TB/lj

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G046 | A. BUILDING 02<br>B. WING _____ | 01/26/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BELMONT CARE CENTER | 3625 VAUGHN ST<br>POCATELLO, ID 83204 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| K 000 | INITIAL COMMENTS<br><br>The facility was built in 1991 and is a one story, Type V(III) structure with a daylight basement that contains offices. Clients sleep on the first story (i.e., ground level). The basement has an exit to finished grade level as well as secondary exiting capability via internal stairwell. Emergency lighting is provided. The facility is fully sprinklered and is licensed for 15 beds. The facility had a census of fourteen clients on the day of the survey.<br><br>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 2000 Edition, Chapter 33, Existing Residential Board and Care Occupancies, adopted 11 March, 2003. In accordance with 42 CFR, 483.470.<br><br>The Survey was conducted by:<br><br>Taylor Barkley<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | K 000 | RECEIVED<br>FEB 12 2010<br>FACILITY STANDARDS | |
| K0011 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD<br><br>The facility is housed in a building where the interior is fully sheathed with lath and plaster or other material providing a 15 minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. All columns, beams, girders, and trusses are similarly encased or otherwise provide not less than a ½ hour fire resistance rating. 33.2.1.3.2. | K0011 | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: M. Hallaway — TITLE: Administrator — (X6) DATE: 2/11/10

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| K0011 | Continued From page 1<br>Exception No. 1: Exposed steel or wood columns, girders, and beams (but not joists) located in the basement.<br><br>Exception No. 2: Buildings of Type I, Type II (2,2,2), Type II (1,1,1), Type III (2,1,1), Type IV (1,1,1) construction (See 8.2.1)<br><br>Exception No. 3: Areas protected by approved automatic sprinkler systems in accordance with 33.2.3.5.<br><br>Exception No. 4: Unfinished, unused, and essentially inaccessible loft, attic, or crawl space.<br><br>Exception No. 5: Where the facility achieves an E-score of three or less using the board and care occupancies evacuation capability determination methodology of NFPA 101A, Guide on Alternative Approaches to Life Safety.<br><br>This Standard is not met as evidenced by:<br>Based on observation it was determined that the facility failed to ensure that the interior is fully sheathed with lath and plaster or other material providing a 15 minute thermal barrier, including all portions of bearing walls, bearing partitions, floor construction, and roofs. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>During the facility tour on January 26, 2010 at 9:17 AM it was observed that the ceiling in the maintenance closet had an opening approximately two foot by two foot in size cut out | K0011 | **POC K0011**<br>**483.470(j)(1)(i)**<br>**Life Safety Code Standard**<br><br>The ceiling hole in the maintenance closet will be covered with a material that provides a 15-minute thermal barrier.<br><br>**Person Responsible:** Maintenance, Home Supervisor and Administrator<br><br>**Monitor:** Monthly the Home Supervisor and Maintenance will complete an environmental audit to ensure all walls and ceilings have the proper covering. Quarterly the Administrator will complete environmental audits with maintenance and the home supervisor. | 3/26/10 |

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| K0011 | Continued From page 2<br>of it. The findings were observed and noted by Surveyor and facility Staff. This deficiency affected no clients and one staff in one of two smoke compartments. | K0011 | | |
| K0020 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD<br><br>Interior stairs are enclosed with ½ hour fire barriers, with all openings equipped with smoke-actuated automatic closing or self-closing doors having a fire protection rating comparable to that required for the enclosure. Stairs comply with 7.2.2.5.3. The entire primary means of escape is arranged so that it is not necessary for the occupants to pass from all spaces on that story by construction having not less than a ½ hour fire resistance rating. In buildings of construction other than Type II (000), Type III (200), or Type V (000), the supporting construction is protected to afford the required fire resistance rating of the supported wall. 33.2.2.4.<br><br>Exception No. 1: Stairs that connect a story at street level to only one other story are permitted to be open to the story that is not at street level.<br><br>Exception No. 2: Stair enclosures are not required in buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected throughout by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick response or residential sprinklers. This exception is permitted only if a primary means of escape from each sleeping area still exists that does not pass through a portion of a lower floor, unless that route is | K0020 | **POC K0020**<br>**483.470(j)(1)(i)**<br>**Life Safety Code Standard**<br><br>The doors will be adjusted to fit within the frame allowing them to close properly. The upstairs door will have the arm to the self closing mechanism will be moved forward so it is not stopping the door from closing.<br><br>**Person Responsible:** Maintenance, Home Supervisor and Administrator<br><br>**Monitor:** Maintenance will complete a bi-monthly Fire Life Safety checklist of the facility to ensure the doors remain self-closing and all fire doors are closing properly. Adjustments will be made to the doors as needed to ensure they are closing. Monthly the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly the Administrator will complete environmental audits with maintenance and the home supervisor. | 2/11/10 |

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| K0020 | Continued From page 3<br>separated from all spaces on that floor by construction having a ½ hour fire resistance rating.<br><br>Exception No. 3: Stair enclosures are not required in buildings of two or fewer stories that house prompt evacuation capability facilities with not more than eight residents and are protected by an approved automatic sprinkler system in accordance with 33.2.3.5 that uses quick-response or residential sprinklers. Exception No. 2 to 33.2.2.3 is not used in conjunction with this exception. The exceptions to 33.2.3.4.3 are not used in conjunction with this exception.<br><br>Exception No. 4: In buildings of three or fewer stories that house prompt or slow evacuation capability facilities protected by an approved automatic sprinkler system in accordance with 33.2.3.5, stairs are permitted to be open at the top most story only. The entire primary means of escape of which the stairs are a part is separated from all portions of lower stairs.<br><br>IMPRACTICAL<br>Vertical openings are protected so as not to expose a primary means of escape. Vertical openings are considered protected if separated by smoke partitions in accordance with 8.2.4 that prevent the passage of smoke from one story to any primary means of escape on another story. Smoke partitions have a fire resistance rating of not less than ½ hour. Any doors or openings to the vertical opening are capable of resisting fire for not less than 20 minutes. 32.3.1.1, 33.2.3.1.1<br><br>Exception: Stairs are permitted to be open where complying with Exception No. 2 or Exception No. | K0020 | | |

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| K0020 | Continued From page 4<br>3 to 32.2.2.4 and 33.2.2.4.<br><br>This Standard is not met as evidenced by:<br>Based on observation it was determined that both the upper and lower stairwell doors would not self close when released from the open position. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>During the facility tour on January 26, 2010 at 9:05 AM, it was observed that neither the upper or lower doors to the stairwell would self close. The findings were observed and noted by Surveyor and facility Staff. This deficiency affected all clients and all staff present on the day of the survey. | K0020 | | |
| K0021 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD<br><br>Vertical openings are protected so as not to expose a primary means of escape. Vertical opening are considered protected if separated by smoke partitions in accordance with 8.2.4 that prevent the passage of smoke from one story to any primary means of escape on another story. Smoke partitions have a fire resistance rating of not less than ½ hour. Any doors or openings to the vertical opening are capable of resisting fire for not less than 20 minutes. 32.2.3.1.1, 33.2.3.1.1<br><br>Exception: Stairs are permitted to be open where | K0021 | | |

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| K0021 | Continued From page 5<br>complying with Exception no. 2 or Exception No. 3 to 32.2.2.4, 33.2.2.4.<br><br>This Standard is not met as evidenced by:<br>Based on observation, it was determined that both the upper and lower dumbwaiter shaft doors would not self close when released from the open position. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>During the facility tour on January 26, 2010 at 9:07 AM, it was observed that neither the upper or lower doors to the dumbwaiter shaft would self close. The findings were observed and noted by Surveyor and facility Staff. This deficiency affected all clients and all staff present on the day of the survey.<br><br>Actual NFPA Standard<br><br>2000 NFPA 101<br><br>8.2.4.3.5<br>Doors shall be self-closing or automatic-closing in accordance with 7.2.1.8. | K0021 | **POC K0021**<br>**483.470(j)(1)(i)**<br>**Life Safety Code Standard**<br><br>New self-closing hinges will be purchased and installed on both dumbwaiter doors. The set pins will be covered to ensure staff are not loosening or removing the pins.<br><br>A memo will be sent out to the staff informing them of the regulatory requirements for the self-closing doors and the importance of not removing or loosing the pins.<br><br>**Person Responsible:** Maintenance, Home Supervisor and Administrator<br><br>**Monitor:** Maintenance will complete a bi-monthly Fire Life Safety checklist of the facility to ensure there are no vertical openings between floors. Monthly the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly the Administrator will complete environmental audits with maintenance and the home supervisor. | 3/26/10 |
| K0046 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD<br><br>Utilities comply with Section 9.1. 32.2.5.1, 33.2.5.1 | K0046 | | |

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| K0046 | Continued From page 6<br><br>This Standard is not met as evidenced by:<br>Based on observation it was determined that the facility failed to ensure that utilities complied with Section 9.1. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>1. During the facility tour on January 26, 2010 at 9:09 AM, observation of Room #3 revealed a multiple electrical adapter in use. The findings were observed by Surveyor and facility Staff. This deficiency affected fourteen clients and five staff in one of two smoke compartments.<br><br>2. During the facility tour on January 26, 2010 at 9:10 AM, observation of the powerstrip supplying power to the fish tank revealed the cord entered the wall and it is unknown where the cord gets its source of power. The findings were observed by Surveyor and facility Staff. This deficiency affected fourteen clients and five staff in one of two smoke compartments.<br><br>Actual NFPA Standard<br>2000 NFPA 101<br>9.1.2 Electric.<br>Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code,<br><br>NFPA 70 Section 400<br>400-8. Uses Not Permitted<br>Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:<br>1. As a substitute for the fixed wiring of a | K0046 | **POC K0046**<br>**483.470(j)(1)(i)**<br>**Life Safety Code Standard**<br><br>The multiple electrical adapters used in Room 3 will be removed and a suitable replacement made.<br><br>The source of power for the power strip was identified and removed. A more suitable solution and power source was found.<br><br>**Person Responsible:** Maintenance, Home Supervisor and Administrator<br><br>**Monitor:** Monthly the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. In addition, there will be discussion on inspections that are coming up or needed within the month. The Entrance form provided by Fire Life Safety will be used in the audit and discussions. | 2/11/10 |

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| K0046 | Continued From page 7<br>structure<br>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors<br>3. Where run through doorways, windows, or similar openings<br>4. Where attached to building surfaces<br>Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.<br>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors<br>6. Where installed in raceways, except as otherwise permitted in this Code | K0046 | | |
| K0152 | 483.470(j)(1)(i) LIFE SAFETY CODE STANDARD<br><br>(1) The facility holds evacuation drills at least quarterly for each shift of personnel and under varied conditions to -<br>(i) Ensure that all personnel on all shifts are trained to perform assigned tasks;<br>(ii) Ensure that all personnel on all shifts are familiar with the use of the facility's emergency and disaster plans and procedures.<br><br>(2) The facility must -<br>(i) Actually evacuate clients during at least one drill each year on each shift;<br>(ii) Make special provisions for the evacuation of clients with physical disabilities:<br>(iii) File a report and evaluation on each drill:<br>(iv) Investigate all problems with evacuation drills, including accidents and take corrective action: and<br>(v) During fire drills, clients may be evacuated to | K0152 | | |

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| K0152 | Continued From page 8<br>a safe area in facilities certified under the Health Care Occupancies Chapter of the Life Safety Code.<br><br>(3) Facilities must meet the requirements of paragraphs (i) (1) and (2) of this section for any live-in and relief staff that they utilize.<br><br>This Standard is not met as evidenced by:<br>Based on record review it was determined that the facility failed to hold evacuation drills at least quarterly on each shift. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>During record review on January 26, 2010 at 9:30 AM, revealed that the facility did not have any documentation for having held a third shift drill during the fourth quarter during the the previous twelve months. Findings were witnessed and noted by Surveyor and the facility Administrator. This deficiency affected all clients and all staff present on the day of the survey. | K0152 | **POC K0152**<br>**483.470(j)(1)(i)**<br>**Life Safety Code Standard**<br><br>Belmont will ensure that quarterly fire drills are completed and documented. The fire drills will be documented on the Care Tracker Kiosks. To ensure that Belmont is current on their fire drills, a drill will be run on each shift each month. A schedule for the year has been created to ensure all drills will be run.<br><br>Following each drill the Administrator or Program Director will pull the report from the kiosks to ensure staff did not have an error in the documentation—as AM was put on the PM drill for the 3rd quarter outlined in this report. If an error occurs with this documentation, shift information and time punches will be pulled to support the error in documentation.<br><br>**Person Responsible:** Maintenance Supervisor, Home Supervisor, and Administrator<br><br>**Monitor:** The Maintenance Supervisor and home supervisors will run the fire drills quarterly. They will complete the drills on the Kiosks. Reports will be pulled monthly and checked by the Administrator to ensure the drills were run. In addition, the Administrator or Program Director will ensure there are no errors in the documentation of time in the kiosk. | 3/26/10 |

Bureau of Facility Standards

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| M 000 | 16.03.11 Inital Comments<br><br>The facility was built in 1991 and is a one story, Type V(III) structure with a daylight basement that contains offices. Clients sleep on the first story (i.e., ground level). The basement has an exit to finished grade level as well as secondary exiting capability via internal stairwell. Emergency lighting is provided. The facility is fully sprinklered and is licensed for 15 beds. The facility had a census of fourteen clients on the day of the survey.<br><br>The following deficiencies were cited at the above facility during the annual Fire/Life Safety survey conducted on January 26, 2010. The facility was surveyed under the LIFE SAFETY CODE, 1976 Edition, " Lodging and Rooming Houses " contained in Chapter 11, " Lodging and Rooming House Occupancies " and applicable provisions of Chapters 01 through 07, Chapter 17 and Appendices A and B of the Life Safety Code, Impractical Evacuation Capability in accordance with IDAPA 16.03.11.<br><br>The Survey was conducted by:<br><br>Taylor Barkley<br>Health Facility Surveyor<br>Facility Fire Safety and Construction | M 000 | RECEIVED<br>FEB 12 2010<br>FACILITY STANDARDS | |
| MM327 | 16.03.11.110.02(h) Emergency Electrical Service<br><br>Each facility must provide emergency electrical service for at least the exit passageway lighting, hall lighting, and the fire alarm system.<br>This Rule is not met as evidenced by:<br>Based on observation, it was determined that the facility had not ensured that all emergency electrical lighting was maintained in working order. The facility had a census of fourteen | MM327 | **POC MM 327**<br>**16.03.11.110.02(h)**<br>**Emergency Electrical Service**<br><br>All emergency lighting units in the hallways, stairwells and entrances will be inspected and repaired by Fire Services of America. Bi-monthly facility inspections and testing of the lights will be completed. At least one of these inspections will be documented and discussed in the monthly Safety Meeting.<br><br>**Person Responsible:** Maintenance, Home Supervisor, and Administrator<br><br>**Monitor:** Home Supervisors will complete a bi-monthly Fire Life Safety checklist of the facility to ensure the emergency lighting | 2/12/10 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| M. Hallacy | Administrator | 2/11/10 |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G046 | A. BUILDING 02<br>B. WING _____ | 01/26/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| BELMONT CARE CENTER | 3625 VAUGHN ST<br>POCATELLO, ID 83204 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| MM327 | Continued From Page 1<br><br>clients on the day of the survey.<br><br>The findings include:<br><br>1. Observation on January 26, 2010 at 8:56 AM, disclosed that the two emergency lighting units on the lower level were not functioning upon pressing of the test button. Findings were witnessed and noted by Surveyor and facility Administrator. This deficiency affected no clients and five staff in one of two smoke compartments.<br><br>2. Observation on January 26, 2010 at 9:08 AM, disclosed that the emergency lighting unit in the hall on the upper level was not functioning upon pressing of the test button. Findings were witnessed and noted by Surveyor and facility Staff. This deficiency affected fourteen clients and five staff in one of two smoke compartments. | MM327 | is functioning properly. Monthly the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly the Administrator or Program Director will complete environmental audits with maintenance and the home supervisor. | |
| MM335 | 16.03.11.110.04(a) Diagram of Building<br><br>A diagram of the building showing emergency protection equipment, evacuation routes, and exits must be conspicuously posted throughout the facility. An outline of emergency instructions must be posted with the diagram.<br>This Rule is not met as evidenced by:<br>Based on observation it was determined that the facility failed to ensure that a diagram displaying the location of emergency equipment and evacuation routes were posted in the facility. The facility had a census of fourteen clients on the day of the survey.<br><br>Findings include:<br><br>During the facility tour on January 26, 2010 at | MM335 | **POC MM 335**<br>**16.03.11.110.04(a)**<br>**Diagram of Building**<br><br>Evacuation routes and instructions will be posted in the facility to ensure everyone is aware of the proper procedures.<br><br>**Person Responsible:** Maintenance, Home Supervisor, and Administrator<br><br>**Monitor:** Home Supervisors will ensure the diagrams and instructions remain posted. Monthly the Fire Life Safety checklists will be discussed in Safety Meetings to ensure compliance with all rules and regulations. Quarterly the Administrator or Program | 3/26/10 |

Bureau of Facility Standards

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 13G046 | A. BUILDING 02<br>B. WING _____ | 01/26/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BELMONT CARE CENTER** | **3625 VAUGHN ST POCATELLO, ID 83204** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| MM335 | Continued From Page 2<br><br>9:11 AM revealed that the facility did not have a plan posted. Observations were witnessed and noted by both Surveyor and facility Administrator. This deficiency affected all clients and all staff present on the day of the survey. | MM335 | Director will complete environmental audits with maintenance and the home supervisor. | |